04:14:57 a.m.

PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING B. WING 09G223 08/06/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 16TH STREET. NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 000 W 000 **INITIAL COMMENTS** Received 8/26/100 A recertification survey was conducted from 8/4/2010 through 8/6/2010. The survey was completed utilizing the fundamental survey process. A random sampling of two clients was selected from a residential population of three males and one female with varying degrees of mentel and physical disabilities. The findings of the survey were based on observations and interviews in the home and at three day progrems, as well as a review of the client and administrative records. including the incident reports. W 159 483,430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of one of four sampled clients. ICilient The findings include: The QMRP failed to ensure all staff received 1. Cross reference W189 training on the implementation of a client 's 9/10/10 behavior support plan and the use of their gait

Ta us Any deficiency statement ending with an esterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the petients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

belt. [See W189]

2. The QMRP falled to ensure all staff was

competent in Implementing client's modified

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

2. Cross reference W194

8/10/10

AB) DATE

16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2010 FORM APPROVED OMB NO. 0938-0391

08-26-2010

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE S COMPLE	
		09G223	B. Wit	4G_	·	08/0	6/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	es, INC			REET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, MW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XLS) COMPLETION DATE
W 159	provided the use of the manner prescri	· .	W.	159	3. Cross reference W436		9/10/10
	staff provided meai prescribed. [See W	- '			4. Cross reference W474		8/10/10
	during snack time of was not provided his texture for his meal Order Sheets on 8/Client #1 was preso portion, bits sized, 65/21/2010. Review dated 5/1/2010 reve	g dinner on 8/4/2010 and on 8/5/2010 revealed Cilent #1 is prescribed modified food is. Review of the Physician 's 5/2010 at 3:59 p.m. revealed cribed a "low fat, double chopped meat diet " on of the Nutrition assessment ealed she recommended that "low fat, chopped, soft foods		,	5. Cross reference W194 & W474		8/10/10
	(RN), qualified men (QMRP) and house 10:36 a.m. confirme presented or on file substantiate that the aware of the Nutrition The facility's QMR coordinate services physician and the means (QMR).	acility 's registered nurse tal retardation professional manager (HM) on 8/6/2010 at ad there was no evidence at the time of survey to e primary care physician was onist recommendations. P failed to manage and between the primary care utritionist to ensure Client #1 in the form best to suit his					
W 167	***	FESSIONAL PROGRAM	W 1	67			
DAL CLIC OF	87/02-00 Products Varsions	Obsolete Event ID- H2GG11		Ene	#hr ID: 000222		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I			(X3) DATE SI COMPLE		
		09G223	B. WIN	1G_		08/0	6/ 2010	
	ROVIDER OR SUPPLIER	s, inc		•	REET ADDRESS, CITY, STATE, ZIP CODE 1217 16TH STREET, NW WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
W 167	professional staff to various professional staff to various professional with the stated goal individual program. This STANDARD is Based on observational review, the facility for provision of physical interventions to ensone of two samples. The finding include: [Cross Reference Various professional staff include:	ove available enough qualified to carry out and monitor the all interventions in accordance is and objectives of every plan. Is not met as evidenced by: ion, staff interview and record alled to ensure the consistent all therapy services and the health and safety of I clients. [Client #1]	W	167				
	8/6/2010 revealed to the gait-belt to man around his environmental hand, he support under his a by holding his upperound his environmental	/2010, 8/5/2010 and again on the facility's staff rarely used age Client #1 as he ambulated ment. Staff was observed olding his arm, providing rmpits or holding him steady r torso whenever he walked ment. Both one-to-one staff a different method of I as he walked. /5/2010 at 2:51 p.m. revealed scent Physical Therapy (PT) completed on 2/23/2010. This mended that "[Client #1] a gait belt for ambulation, a and a helmet for safety ady galt and self-injurious			Staff will receive additional training facility's nursing staff on the use of the belt and the walking protocol for Indiana.	he gait	9/10/10	
	walking protocol, ar	nd a helmet for safety ady galt and self-injurious			What I'v 00/3909			

04:15:48 a.m.

PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G223 08/06/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX **ID** (XS) MPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 167 Continued From page 3 W 167 behavior. " Further record review on the same day and time revealed, the PT failed to establish a consistent method for utilizing the gait-belt, failed to ensure the walking protocol incorporated the use of the galt-belt, and Client #1 was still without his helmet. Interview with the facility 's House Manager (HM), Registered Nurse (RN) and the qualified The Physical Therapist will be consulted for mental retardation professional (QMRP) on further clarity on the type of helmet for 8/5/2010 at 5:05 p.m. confirmed the attending PT Individual #1. In the future, QMRP's will had not provided any services since his written review recommendation for specific assessment on 2/23/2010. Further interview with 9/10/10 instructions when adaptive equipment is the facility 's HM and RN revealed they were not required. sure what type of heimet Client #1 needed. Attempts to clarify the type of helmet Client #1 needed with the previous PT had been met with no success. According to interview, the PT who wrote the 2/23/2010 assessment resigned and was no longer providing services to the facility. As of the date of survey, there was no evidence that the facility had secured the services of a Physical Therapist to ensure Client #1 's health and safety. W 189 483.430(e)(1) STAFF TRAINING PROGRAM W 189 The facility must provide each employee with initial and continuing training that enables the

employee to perform his or her duties effectively.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff

received training on the implementation of a client s behavior support plan and the use of their gait belt for one of two sampled clients. [Client #1]

efficiently, and competently.

04:16:06 a.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	(X3) DATE & COMPLE	
		09G223	B. WING_		08/0	6/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	18, INC		REET ADDRESS, CITY, STATE, ZIP CODE 5217 16TH STREET, NW WASHINGTON, DC 20012		•
(X4) ID PREFIX TAG	X. (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 189	The finding included by the gait-beit as they balance as he amb environment. Staff hand, holding his air his armpits or holding his armpits or holding he walked around he survey. Both staff if of supporting Client in addition, one his holding Client #1 's from knocking over on the table during approximately 5:15. Record review on 8 revealed Client #1 'Therapy (PT) asset 2/23/2010. This as Client #1 be provided walking protocol, ar Further record reviewed walking protocol, ar Further record reviewed Client #1 '(BSP) dated 4/25/20" Non-Violent Physishould only be used #1 is a danger to sephysical crisis intansafe, non-harmful coafely control [Clien control of his behave procedure/restraint.	/2010, 8/5/2010, and again on the facility's staff rarely used a managed Client #1's ulated around his was observed holding his man providing support undering him by his upper torso as his environment. Two of Client aff was observed during the mplemented different methods that as he walked. one-to-one staff was observed arms and preventing him the food and utensils that was the evening of 8/4/2010 at p.m. //5/2010, at 2:51 p.m., s most recent Physical sessment was completed on sessment recommended that ad a gait belt for ambulation, and a helmet for safety. ew on 8/5/2010, at 2:30 p.m., s Behavior Support Plan 010 outlined the following: local Crisis Intervention: this is as a iast resort when Client elifor others. Non-vioient vention involves the use of ontrol and restraint position to the fall until he can regain	W 189	Staff who are assigned to work with #1 will receive training on his BSP, protocol and the MANDT certification.	walking	9/10/10

PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 09G223 08/06/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 16TH STREET, NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LIC IDENTIFYING INFORMATION) TAG DEFICIENCY W 189 W 189 Continued From page 5 nonviolent crisis intervention procedures developed by organizations such as MANDT. " Interview with the house manager (HM) and qualified mental retardation professional (QMRP) on 8/5/2010, at 5:18 p.m., revealed three out of the five staff assigned to Client #1 as a one-to-one staff did not receive training on Client #1 's behavior support plan or received training on the use of the gait belt. Additional interview and record review with the HM and the QMRP on the same day and time confirmed all staff assigned to Client#1 should have received training on both his behavior support plan and the use of his gait beit. 483.430(e)(4) STAFF TRAINING PROGRAM W 194 W 194 Staff must be able to demonstrate the skills and Staff will receive additional training on Individual techniques necessary to implement the individual #1 modified food texture as indicated in his program plans for each client for whom they are prescribed diet by the facility's nutritionist. responsible. , QMRP and Residential Manager will monitor at 8/10/10 maaltima daily to ensure that all staff are in compliance. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility falled to ensure all staff was competent in implementing client 's modified food texture for one of the three sampled clients. [Client #1] The finding includes: [Cross Reference W474]

Client #1 was not provided a "bite size" textured meal on the evening of 8/4/2010. The turkey meat he was provided was pulled from the bone in long strips and served accordingly. Client #1 was also observed being served crunchy

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

<u>O-11161</u>	10101111223	O MICDIONED OFFICE				CIND NO.	0000-0001
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		09G223	B. WIN	4G _		08/0	8 <i>/</i> 2010
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY MULTI SERVICE	s, inc			217 16TH STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)		PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			COMPLETION DATE
W 194	Continued From pa	ge 6	W.	194			
W 331	cheese doodles for 8/5/2010 despite his chopped soft diet. retardation professi manager (HM) later the cheese doodles	snack on the afternoon of s recommendation for a The facility 's qualified mental onal (QMRP) and the house r confirmed that the meat and s were served in error. The e would address the oversight	Wa	331	The primary care nurse will review m	nedical	
	The facility must provide clients with nursing services in accordance with their needs.				records on a weekly basis to ensure appointments are scheduled on time. When sedation is requested the primary care nurse will ensure that sedation is administered prior		
	Based on staff inter facility's nursing st services to ensure a	s not met as evidenced by: view and record review, the aff falled to coordinate timely a client could receive timely allow-up for one of two lient #1]			to appointments. The Director of Nur review medical records on a monthly ensure medical services are rendere	basis to	9/13/10
	The finding includes	3;					
	Client #1 's 1/4/201 identified he had a cauliflower ear malf treatment could not behavior. A second attempted on 4/6/20	/5/2010 at 3:00 p.m. ravealed 0 Audiology appointment " cerumen impaction and ormation left [ear]. The be completed due to his I Audiology assessment was 010 and again he was not able columnent. The 4/6/2010 he following					
	(attempts in past ha patient resistance). 2. Return when ea	for cerumen removal tive been unsuccessful due to ursuccessful due					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SI COMPLE	
		09G223	B, WING		08/0	8/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	s, INC	8	TREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 356	permissible as this being tested. Non-used for testing if the Further record review revealed this client 1/6/2010 Renal Son appointment which 1/4/2010. Interview nurse (RN) on 8/6/2010 Collent #1 was not appointments and abje to complete his 483.480(g)(2) CONTREATMENT The facility must entreatment services needed for relief of restoretion of teeth health. This STANDARD is Based on observation of teeth health. This STANDARD is Based on observation of teeth health. The finding include: Observation 8/5/20 revealed, Client #1 discolored. Record	patient is highly resistant to behavioral measures can be ne patient is quiet/asleep. The won 8/6/2010 at 12:30 p.m. received sedations for a negram and an ENT he successfully completed on with facility 's registered 2010 at 10:57 a.m. confirmed, edated for his audiology because of that, he was not appointment. The EMENSIVE DENTAL The sure comprehensive dental that include dental care pain and infections, and maintenance of dental is not met as evidenced by: lon, staff interview and record alled to ensure timely dental for one of two sampled	W 35	-	ental e will also the	9/15/10
		dings: Comprehensive exam, Patient needs scaling. Will	•			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		09G223	B. WIN	IG_		08/0	B/2010
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW		
COMMU	KITY MULTI SERVICE	28, INC		W	ABHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 356	Continued From pa	-	W:	356			
	submit for pre-auth	orization.					
	11/25/2009: Appoin	gistered nurse (RN) note atment cancelled, because the ing on pre-authorization.					
	heavy calculus dep Recommendation:	lings: Comprehensive exam, osits. Patient needs scaling. will submit pre-authorization to val. Will cell to reschedule to next visit.					
	confirmed there has authorization proble treatment. The RN oral health has dec care. The RN state attempts at securin concedes pre-authorizations.	on 8/6/2010, at 10:43 a.m., is been a lapse in care due to small with securing timely also confirmed Client #1 's lined due to the lapse in dental at the has made several g timely services, but also crization has been a consistenting timely dental treatment.			•		
W 369	timely dental servic Client #1 's oral he	ensure Client #1 received es to manage and maintain aith since 9/16/2009. G ADMINISTRATION	w:	369			. :
	that all drugs, include	g administration must assure ding those that are are administered without error.			·		
	Based on observati review, the facility	is not met as evidenced by: ion, staff interview and record is nursing staff failed to ensure is administered as ordered for if clients. [Client #2]				•	
	The finding Includes	s:					

PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES . AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING **D9G223** 08/06/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XIS) COMPLETION DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 369 W 369 Continued From page 9 Observation on the evening of 8/4/2010 revealed The Director of Nursing met with the nursing Client #1 did not receive his prescribed dosage of staff and reviewed policies and procedures on 15mg of Zyprexa, interview and record review medication administration and the primary with the facility 's registered nurse (RN) on care nurses's responsibilities to ensure all 8/6/2010, at 11:30 a.m., confirmed the medication prescribed medications are available. The was not provided. Further record review revealed nursing staff who falled to administer the the medication was not provided for a total of four medication and failed to report on time (4) days (8/2/, 8/3/, 8/4/, 8/5/). Further interview 8/19/10 received disciplinary action. with the RN on the same day and time revealed the medication arrived to the facility on 8/5/2010. but was not administered that evening. The facility 's nursing staff falled to enforce and implement an effective system to ensure that all medications were administered as prescribed to ensure the health and safety of its clients. W 376 483.460(k)(8) DRUG ADMINISTRATION W 376 The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the primary care physician was informed of missed medications to ensure the health and safety of one of two sampled clients. [Client #2] The finding includes:

[Cross reference W369]

Observation on the evening of 8/4/2010 revealed Client #1 did not receive his prescribed dosage of 15mg of Zyprexa. Interview and record review with the facility 's registered nurse (RN) on

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		09G223	B. WIN	IG		08/0	6/2010
NAME OF P	ROYDER OR SUPPLIER	**************************************			EET ADDRESS, CITY, STATE, ZP CODE	, <u>, , , , , , , , , , , , , , , , , , </u>	
COMMU	NITY MULTI SERVICE	EB, INC			217 18TH STREET, NW VASHINGTON, DC 20012		
(X4) ID . PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(XS) COMPLETION DATE
W 436	was not provided. Interview with the fe and time revealed i yet to be notified of the Zyprexa since & identified as not be identified as not be implement an effect primary care physic medications errors safety of its clients. 483.470(g)(2) SPA(The facility must fur and teach clients to choices about the unhearing and other devices in	a.m., confirmed the medication Further record review and acility 's RN on the same day he primary care physician had the missed administration of \$22/1010 when it was first ing available. In staff falled to enforce and tive system to ensure that the clan is informed of all to ensure the health and CE AND EQUIPMENT mish, maintain in good repair, use and to make informed is of dentures, eyegiasses, communications aids, braces,	W 4		Cross reference W369		8/19/10
	Based on observation review, the facility from the facility from the sampled clients were adaptive equipment safety. [Client #1] The findings includes 1. Observation on 4:15 p.m. and again revealed Client #1 wor a sip cup for his sip cup	s not met as evidenced by: on, staff interview and record alled to ensure one of two re provided the proper t for meals and for personal 6: 6/4/2010 at approximately at approximately 5:20 p.m. was not provided a plate guard snack and dinner respectively. ad dinner, food feli from his g room floor as he attempted			Individual #1 will be provided with guard and sip cup as recommended nutritionist. QMRP and Residential Mwill monitor to ensure usage during nancks. The nutritionist will review the recommendations and make correctled.	by the lanager neals and e OT	9/10/10

04: 18: 03 a.m.

08-26-2010

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PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 09G223 08/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 16TH STREET, NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (X5) MPLETION DATE BUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG **DEFICIENCY** W 436 W 436 Continued From page 11 Residential staff will receive training on the use to eat with hand-over-hand assistance. There of the appropriate adaptive equipment for was also heavy spillage of his beverage during individual #1. 9/10/10 both snack and dinner due to him not being provided a sip cut for him to use during those meals. Record review on 8/5/2010 at 3:59 p.m. revealed Client #1 's 5/1/2010 Nutritional assessment identified he utilizes a plate guard and a sip cup during meals. Interview with the facility 's registered nurse (RN) on 8/8/2010 at 10:38 a.m. confirmed Client #1 should have been afforded the opportunity to drink from a sip cup and also should have been provided a plate guard during his meals as recommended. 2. [Cross Reference W167] Client #1 was never observed wearing a helmet The helmet will be ordered for Individual #1 during survey between the dates of 8/4/2010 and 9/10/10 as recommended by the Physical Theraplat. 8/8/2010. Record review on 8/6/2010 at 1:22 The primary care nurse will review all p.m. revealed he had a fall on 11/1/2009 and recommendations and Implement in a timely sustained minor injury. Record review on manner. 8/5/2010 at 1:22 p.m. revealed on 4/7/2010 the facility 's Committee for the investigation of Unusual Incidents reviewed the 11/1/2009 incident and concluded that Client #1 should be provided a helmet to ensure his health and safety. Interview with the facility 's registered nurse (RN) and house manager (HM) on 8/6/2010 at 5:05 p.m., confirmed the helmet was still pending. In

addition, the RN indicated that the Physical Therapist's (PT) recommendation was not clear. He was not sure what "type" of helmet was needed or was being recommended. Moreover, the PT that made the recommendation has since

04:18:20 a.m.

08-26-2010

14/26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
	<u>:</u>	09G223	B, Win	IG		08/00	3/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	ES, INC		6.	REET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW VASHINGTON, DC 20012		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 438	Continued From paresigned from his davailable for consult the facility failed to helmet as recommon safety. 483.480(b)(2)(iii) M. Food must be served developmental level their meal as prescribed. This STANDARD I Based on observation review, the facility freceived their meal as prescribed. The findings including Deservation on the approximately 5:15 served a regular tax meat, stuffing, mass and a biscuit. Received their received their received their received their received their received their meat, stuffing, mass and a biscuit. Received the received their received th	luties (5/2010) and is no longer litation. I ensure Client #1 received his ended to ensure his health and lEAL SERVICES ed in a form consistent with the el of the client. Is not met as evidenced by: lon, staff interview and record failed to ensure all clients is in the form and consistency e: evening of 8/4/2010 at p.rn., revealed Client #1 was extured meal of pulled turkey shed sweet potatoes, colesiaw ord review on 8/5/2010 at 3:59 ont #1's physician's orders live a "low fat, double portion, it meat diet." In addition, on was observed being served odles as part of his snack. scillity's qualified mental ional (QMRP) on 8/6/2010 at ed Client #1 did not receive his eduring dinner on the evening	W	436	DEFICIENCY)	or will o ensure ed diet. All	8/10/10
	QMRP and the faci would work to addr staff immediately.	snacks on 8/5/2010. The illty's nurse indicated they ess that oversight and re-train					
아이네 아니오 기	87/02-00 Province Versions	Dhacists Event ID: H2GG1	1	Fac	NEW ID: 00G-223 If models	mation about t	Jana 12 <i>ni</i> 14

04:18:37 a.m.

08-26-2010

15 /26

PRINTED: 08/19/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 09G223 08/06/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8217 16TH STREET, NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE (X4) ID PREFIX TAG PREFIX TAG DEFICIENCY) W 474 Continued From page 13 W 474 The facility failed to ensure Client #1 was provided a "bite sized, chopped meat" diet as prescribed.

FORM CMS-2667(02-99) Previous Versions Obsciete

Event ID: H2GG11

Facility ID: 09G223

if continuation sheet Page 14 of 14

TATEMENT IND PLAN C	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223			(X2) MULT A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED - 08/06/2010	
IAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP GODE		
COMMUN	KITY MULTI SERVICI	ES, INC	6217 16TI WASHING	H STREET, STON, DC	NW 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X8) COMPLET DATE
1 000	8/4/2010 through 8 A random sampling from a residential pone female with va The findings of the observations and in three day programs	rey was conducted fro	s selected ales and bilities. In and at of the	1 000			
I 055	3502.13 MEAL SEI Each GHMRP shall proper feeding tech appropriate use to	RVICE / DINING ARE ill train the staff in the nniques and monitor t assist residents who acedures or utensils.	use of heir	1 055	The staff will receive training of diet for Individual #1. QMRP and Manager will monitor daily at necessary prescribed diet.	ınd Residentiai	8/10/10
	Based on observat review, the facility f received their meal	met as evidenced by ion, staff interview an failed to ensure all rests in the form and conne of two residents in #4)	d record sidents sistency	٠			
	approximately 5:15 was served a regulturkey meat, stuffin colesiaw and a bisc 8/5/2010 at 3:59 p. physician 'e orders fat, double portion, 'In addition, on 8/2010 at 15:15 p. In addition, on 8/2010 at 15:15 p.	e: evening of 8/4/2010 p.m., revealed Resid ar textured meal of programmer potential. Record review of m. revealed, Resident prescribed he receive bite sized, chopped m/5/2010, Resident #1 ved crunchy cheese	ent#1 ulled atoes, n t #1 ' s e a " low neat diet.				·

STATE FORM

H2GG

f continuation sheet 1 of 11

Health F	Regulation Administra	ation					· · · · · · · · · · · · · · · · · · ·
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL' A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED	
	 	09G223				08/9)6/2010
NAME OF P	ROVIDER OR SUPPLIER				, STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE	8, INC		H STREET, STON, DC			
(X4) ID. PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
1 055	Continued From pa	ge 1		1 055			
	as part of his snack.						
•	retardation professi 10:36 a.m. confirmed his correct food text evening of 8/4/2010. The QMRP and the they would work to re-train staff immed. The facility falled to	acility 's qualified me ional (QMRP) on 8/6 ed Resident #1 did no ture during dinner on and for snacks on 6 facility 's nurse India address that oversig liately. ensure Resident #1 zed, chopped meat "	2010 at ot receive in the W5/2010. Cated hit and was				
1 090	3504.1 HOUSEKEE	EPING	ĺ	1 080			
	maintained in a safe and sanitary manne	erior of each GHMRI e, clean, orderly, attra er and be free of rt, rubbish, and objec	activ e ,				
	Based on observations of the interior of maintained in a safe	met as evidenced by on, the GHMRP falle of the GHMRP was e, clean, orderly, attra four of four residents	d to active and				
Ì	The findings include):					
	During the environm 4/21/2010, at 5:20 p were observed:	nental inspection on o.m., the following de	ficiencles				
İ		n the bathroom near ely loose and could b th little effort.			The toilet seat in the bathroom neakitchen was repaired.	ar the	B/24/10

STATE FORM

04:19:18 a.m.

18/26

PRINTED: 08/19/2010 FORM APPROVED

08-26-2010

Health F	tegulation Administra	tion				, -,		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED		
		08G223	ETOCET AN	ET ADDRESS, CITY, STATE, ZIP CODE			08/06/2010	
NAME OF P	ROVIDER OR SUPPLIER				•			
COMMÚ	NITY MULTI SERVICE	s, inc	WASHING	H STREET, ITON, DC 2	NY 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JID BE	(XS) COMPLETE DATE	
1 090	Continued From pa	ge 2		1 090				
·	was observed both bedrooms. In addit	lation of dust on the / In Resident #1 and a tion, the vent in Residen and hanging off th	12 's ient #1 's		Dust on the A/C vents for individu #2 was removed and cleaned.	al #1 and	8/24/10	
	3. Holes were observed in the plaster along the walls in Resident #1 's bedroom.		along the		The holes in the wall in Individual #1 bedroom will be repaired.		B/24/10	
. 400	extremely worn and	•			4. The floors in Individual #1 bedroom will be repaired.		8/24/10	
! 180	Each GHMRP shall administrative supp needs of the resider Habilitation plans. This Statute is not Based on observation review, the group here person is GHMRP professional (QMRF coordination of servand safety of one of [Resident #1] The findings included the continuous of the findings included the continuous of the implementation on the implementation on the implementation of the implementati	provide adequate out to efficiently meet as avidenced by on, staff interview anome for the mentally qualified mental retailed to ensure the item sampled resides to promote the item sampled resides to ensure all staff itementation of a reside	elr d record retarded ardation e nealth nts. recalved ent 's	I 180	1. Cross reference W189		9/10/10	
j	belt. [See Federal I W189] 2. The QMRP faile competent in Impler	an and the use of the Deficiency Report Cit and to ensure all staff v nenting resident's m	was nodified		2. Cross reference W194 & W474		8/10/10	
	food texture, [See F	ederal Deficiency Re	port					

<u>Health</u> R	equiation Administra	1000					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE 08/0	
NAME OF B	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE		
	NITY MULTI SERVICE	:8, INC	6217 1611	H STREET, STON, DC 2	MA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
l 180	provided the use of the manner prescri	ed to ensure residen f their adaptive equip bed on their habilitati lency Report Citation	ment in ion plans.	l 180	3. Cross reference W436		9/10/10
	staff provided meal	QMRP failed to ensure the residential vided meals in the form and texture as ed. [See Federal Deficiency Report			4. Cross reference W474		8/10/10
	5. (Cross Referent Citations W194 & V	ice Federal Deficient N474]	y Report		5. Cross reference W194 & W474		8/10/10
	during snack time of #1 was not provide texture for his meal Order Sheats on 8/ Resident #1 was pr portion, bite sized, 5/21/2010. Review dated 5/1/2010 review	g dinner on 8/4/2010 on 8/5/2010 revealed dhis prescribed modes. Review of the Phys/5/2010 at 3:59 p.m. in rescribed a "low fat, chopped meat diet" of the Nutrition assembled she recommen "low fat, chopped, see led she recommen of the Nutrition assembled she recommendate the Nutrition assembled she not	Resident lified food ysician's revealed double on essment				
	(RN), qualified mer (QMRP) and house 10:36 a.m. confirm presented or on file substantiate that th	acility 's registered nated retardation profes manager (HM) on 8 and there was no evide at the time of survey a primary care physicalst recommendation	ssional /6/2010 at ence / to clan was			į	
	coordinate services physician and the n	P falled to manage as between the primary substitutionist to ensure fals in the form best to	y care Resident				

Health Regulation Administration STATE FORM

Health Regulation Administration								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2010				
NAME OF I	PROVIDER OR SUPPLIER	700229	STREET AD	DRESS CITY	STATE, ZIP CODE	אפט ו	16/2010	
GOSTALINITY AND THE SERVICES AND			H STREET, STON, DC	NW				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION 8 HOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD RE COMPLETE		
202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.			l 202	Staff #12 and #13 will review their joi description and sign.	b	8/10/10	
l 205	description, which details each of his or her major responsibilities and duties and supervisory		ew, the erson provided a section. IMRP's (QMRP), revealed arrent files. ewritten, he duties sew, the rson's set the ers at	l 20 5	QMRP and Residential Manager will and review job description annually w#12 and #13.		8/10/10	

Health Regulation Administration									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 09G223		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2010					
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·			
6217 16TH			1 STREET, I						
(X4) ID PREFIX TAG	BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE COMPLETE PATE			
l 205	Continued From page 5 Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 8/6/2010 at approximately 4:52 p.m. revealed there was no written evidence that the facility's supervisor afforded two put of thirteen staff the opportunity to discuss and review their current job description over the past year.			1 205					
228				Staff will receive additional training of Individual #1's Behavior Support Plause of the gait belt. QMRP end Resi Manager will provide supervision and ality.	n and the dential	B/10/10			

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Health Regulation Administration									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI DENTIFICATION N 09G223			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED - 08/06/2010				
			STREET AD	ORESS, CITY,	STATE, ZIP CODE				
8217 16TH			STREET, I						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLETE ICED TO THE APPROPRIATE DATE			
l 229	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		1 229						
111 45	aidam Aidanlaitatantina	<u> </u>	ا بــــــــــــــــــــــــــــــــــــ						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: 09G223		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(XS) DATE SURVEY COMPLETED 08/06/2010					
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE				
6217 16TI			H STREET, STON, DC 2						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX · TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
1229	Continued From pa	ge 7		229					
à	Resident #1 should have received training on both his behavior support plan and the use of his gait belt.								
1 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training		1422	QMRP and Residential Manager v at mealtime daily to ensure that in is served his prescribed diet. Cros	dividual #1				
	and assistance to residents in accordance with the resident's Individual Habilitation Plan.				W474		8/10/10		
	Based on observati review, the group in person (GHMRP) for competent in imple	met as evidenced by ion, staff interview an orne for the mentally alled to ensure all sta menting a resident ' s rotocol for one of the [Resident #1]	d record retarded iff was			:			
	The findings include	9:							
; ;	[Cross Reference F Citation W474]	ederal Deficiency Re	eport						
	textured meal on the turkey meat he was bone in long strips a Resident #1 was all crunchy cheese do afternoon of 8/5/20 recommendation for	r a chopped soft diet	O. The from the ply. British the ply. Br						
	(QMRP) and the ho confirmed that the r were served in erro	mental retardation pro- cuse manager (HM) is meat and the cheese r. The QMRP indical oversight immediately	ater doodles led she						
1 430	3521.7(a) HABILITA	ATION AND TRAININ	IG	1430					

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G223 08/08/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6217 16TH STREET, NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 1430 1430 Continued From page 8 Cross reference W167 9/10/10 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners. use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure one of two sampled residents were provided the proper adaptive equipment for meals for one of two sampled residents. [Resident #1] The finding includes: Observation on 8/4/2010, at approximately 4:15 p.m. and again at approximately 5:20 p.m. revealed, Resident #1 was not provided a plate guard or a sip cup for his snack and dinner respectively. During his snack and dinner, food fell from his plate onto the dining room floor as he attempted to eat with hand-over-hand assistance. There was also heavy spillage of his beverage during both snack and dinner due to him not being provided a sip cup for him to use during those meals. Record review on 8/5/2010, at 3:59 p.m., revealed Resident #1 's 5/1/2010 Nutritional assessment identified he utilizes a plate quard and a sip cup during meals. Interview with the facility 's registered nurse (RN) on 8/8/2010 at 10:36 a.m. confirmed Resident #1 should have been afforded the opportunity to drink from a sip cup and also should have been provided a plate guard during his meals as recommended.

Health Regulation Administration

Health Regulation Administration								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
09G223				08/0	8/06/2010			
NAME OF P	ROVIDER OR SUPPLIER	·			STATE, ZIP CODE		1	
COMMU	NITY MULTI SERVICE	S, INC		H STREET, STON, DC 2				
(X4) ID PREFIX TAG	BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETE DATE		
I 441	3521.7(k) HABILITATION AND TRAINING			1441	Cross reference W167		9/10/10	
٠	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:			0 0 0 0 0 0			8/10/10	
	(k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment);							
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure one of two sampled residents were provided the proper adaptive equipment for personal safety during ambulation for one of two sampled residents. [Resident #1]							
	The finding includes	5 :						
	[Cross Reference F Citation W167]	ederal Deficiency Re	port					
	helmet during surve 8/4/2010 and 8/6/20 8/6/2010 at 1:22 p.m 11/1/2009 and sust review on 8/5/2010 4/7/2010 the facility investigation of Unu 11/1/2009 incident 8 #1 should be provid health and safety. At the same day and the s		of on fail on tecord d on e ved the tesident te his sw on					
	and house manage p.m., confirmed the addition, the RN ind	icility 's registered no r (HM) on 8/6/2010 a helmet was still pend icated that the Physic penmendation was	t 5:05 ling. In cal					

Health R	equiation Administra	#UQ11					<u> </u>
AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G223	er/CLIA IMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		490220	STREET AN	DRESS CITY S	ITATE, ZIP CODE		-,,
NAME OF P	ROVIDER OR SUPPLIER			H STREET, N			
COMMU	NITY MULTI SERVICI		WASHING	TON, DC 20	XX12		
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1441	Continued From particles was not sure with needed or was being the PT that made to resigned from his cavailable for consumers.	age 10 hat "type" of heiming recommended. In he recommendation duties (5/2010) and is	et was Aoreover, has since s no longer	I 441	DEFICIENC	Y	
			·				